Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

ORTHOTEXAS PHYSICIANS & SURGEONS
4780 N JOSEY LN
CARROLLTON, TX 75010

Respondent Name

STATE OFFICE OF RISK MANAGEMENT

Carrier's Austin Representative Box

Box Number 45

MFDR Tracking Number

M4-12-2322-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "On this date of service, the treatment was denied as untimely filing. We file our claims electronically and I have attached a report from our clearinghouse verifying that this was received by your company in a timely manner."

Amount in Dispute: $98.63

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Office is unable to verify the information that the requestor submitted as proof of timely filing, as this shows a date of service but does not show the billed charges to justify which bill was actually sent to the Office on 7/1/2011l. The Office did not receive a bill for date of service 6/20/2011 billing with CPT codes 99213 and 99080-73 until 12/14/2011 (Exhibit II) which is 177 days from the date of service. The Office considered this as the initial submission of this date of service…The Office received a request for reconsideration on 1/19/2012 (Exhibit III) billing with identical codes and charges, an audit was performed and a denial issued for 29-Time limit for filing has expired."

Response Submitted by: State Office of Risk Management, P.O. Box 13777, Austin, TX 78711

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 20, 2011	99213, 99080-73	$98.63	$98.63

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.

2. 28 Texas Administrative Code §129.5 sets out the procedures and reimbursement for Work Status Reports.
3. 28 Texas Administrative Code §133.20 sets out the procedures for health care providers to submit workers' compensation medical bills for reimbursement.
4. 28 Texas Administrative Code §134.203 sets out the guidelines for reimbursement for Professional Services.
5. 28 Texas Administrative Code §102.4 sets out the rules for non-Commission communications.
6. Texas Labor Code §408.027 sets out the rules for timely submission of a claim by a health care provider.
7. Texas Labor Code §408.0272 sets out the rules for certain exceptions for untimely submission of a claim by a health care provider.
8. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated December 16, 2011
   - 29-The time limit for filing has expired.

   Explanation of benefits dated January 20, 2012
   - 29-The time limit for filing has expired.
   - 193- Original payment decision is being maintained. This claim was processed properly the first time.

Issues

1. Did the requestor submit the medical bill for the services in dispute timely and in accordance with 28 Texas Administrative Code §133.20?
2. Did the requestor submit documentation to support the disputed bills were submitted timely in accordance with Texas Labor Code, Section §408.027 and 28 Texas Administrative Code §102.4?
3. Is the requestor entitled to reimbursement?

Findings

1. Pursuant to 28 Texas Administrative Code §133.20(b) states in pertinent part "Except as provided in Texas Labor code §408.0272…a health care provider shall not submit a medical bill later than the 95th day after the date the services are provided." No documentation was found to support that Texas Labor Code §408.0272 applies to the service in dispute. For that reason, the requestor in this dispute was required to send the medical bill no later than 95 days after the service in dispute was provided. 28 Texas Administrative Code §102.4(h) states "Unless the great weight of evidence indicates otherwise, written communications shall be deemed to have been sent on: (1) the date received, if sent by fax, personal delivery, or electronic transmission or, (2) the date postmarked if sent by mail via United States Postal Service regular mail, or, if the postmark date is unavailable, the later of the signature date on the written communication or the date it was received minus 5 days. If the date received minus five days is a Sunday or legal holiday, the date deemed sent shall be the next previous day which is not a Sunday or legal holiday."

   Review of the documentation submitted by the requestor finds a copy of Claim History Report from RealMed, the clearinghouse for requestor. The report shows that the electronic claim submitted to respondent was confirmed and accepted by the respondent on 07/01/2011.
2. In accordance with Texas Labor Code §408.027, the Requestor has timely submitted bill to the respondent. The requestor's documentation supports the services rendered. Therefore, reimbursement is recommended as follows:

   CPT code 99213: 54.54 WC CF/33.9764 Medicare CF x 66.90 Participating amount = $107.39. The requestor is seeking $83.63. This amount is recommended per Texas Administrative Code § 134.203.

   CPT code 99080-73: $15.00 is recommended per 28 Texas Administrative Code §129.5(i)

Conclusion

For the reasons stated above, the division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is $98.63.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to

additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $98.63 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	04/13/2012 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.